No. 80-802

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IN THE

Supreme Court of the United States

October Term, 1980

NATIONAL GERIMEDICAL HOSPITAL
and GERONTOLOGY CENTER,

Petitioner,

—v.—

BLUE CROSS OF KANSAS CITY and
BLUE CROSS ASSOCIATION,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR RESPONDENTS

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QUESTION PRESENTED

The National Health Planning and Resources Development Act of 1974 directs federally designated Health Systems Agencies to prepare regional Health Systems Plans to regulate hospital construction, and to "implement" these Plans in cooperation with private health care insurance providers such as Blue Cross.

In this case, a hospital was constructed in disregard of a determination by a Health Systems Agency, acting under authority of the Health Planning Act, that additional hospital beds in its area were unnecessary. The hospital applied to Blue Cross for a reimbursement contract; Blue Cross, allegedly in concert with the Health Systems Agency and others, adhered to its policy of contracting only with hospitals that had been granted the Health Systems Agency's approval, thereby implementing the Health Systems Plan.

The question presented is whether the Health Planning Act of 1974 impliedly repealed the antitrust laws with respect to this specific conduct.

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BLUE CROSS OF KANSAS CITY and
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Respondents.

BRIEF FOR RESPONDENTS

This brief is submitted on behalf of respondents Blue Cross of Kansas City and Blue Cross Association.

STATUTORY PROVISIONS INVOLVED

The statutes involved in this case are set forth in the Appendix at the end of this brief. These include Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, and certain provisions of the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.* The 1974 Act, the statute involved in this case, was amended in 1979. Pub. L. No. 96-79, 93 Stat. 592.

STATEMENT OF THE CASE

In 1974 this country was confronted with the problem of "overbedding"—a surplus of hospital beds. The high cost of maintaining excess beds (or "inpatient" facilities, as hospital beds are commonly termed) was determined to be a chief contributor to the burgeoning inflation in the cost of health services. In response, Congress enacted the National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225, 42 U.S.C. §§ 300k *et seq.* (the "Health Planning Act of 1974"), to prevent the "unnecessary duplication of health resources" and, specifically, the construction of duplicative inpatient facilities. This duplication was deemed by Congress to increase the cost of health services.

The 1974 Act authorized creation of federally designated and funded Health Systems Agencies ("HSAs"), each of which was charged with developing a regional Health Systems Plan to serve as a blueprint for future development by all participants in the local health care community. 42 U.S.C. § 300*l*-2(b). Each HSA was directed to "implement its [Health Systems Plan] with the assistance of individuals and public and private entities in its health service area." 42 U.S.C. § 300*l*-2(c)(1).

In 1976, Mid-America Health Systems Agency ("MAHSA") was conditionally designated by the Secretary of Health, Education and Welfare (now Health and Human Services) as the HSA for the region encompassing metropolitan Kansas City. (J.A. 202a-03a).[1] MAHSA is a federally funded not-for-profit corporation. (J.A. at 34a; 42 U.S.C. § 300*l*-5). As required by the Health Planning Act of 1974, its board of directors represents a broad cross-section of the community, consisting of consumers of health care and "providers," including hospi-

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1 As used herein, "J.A." refers to the Joint Appendix; "D.R." refers to the Designated Record on Appeal; "Pet. Br." refers to the petitioner's brief; "S.G. Br." refers to the brief of the United States as *amicus curiae*; "F.A.H. Br." refers to the brief of the Federation of American Hospitals as *amicus curiae*.

tals and third-party payers such as Blue Cross Plans. 42 U.S.C. § 300*l*-1(b)(3)(C)(i),(ii)(III). Congress found that since the provider is "one of the most important participants" in the health care sector, "it is *imperative* that the provider be encouraged to play an active role in developing health policy *at all levels.*" 42 U.S.C. § 300k(a)(5) (emphasis added).

Pursuant to its statutory responsibilities, MAHSA developed a Health Systems Plan ("HSP"), which was formally adopted as the five-year plan for the region in 1977. (Relevant sections of the HSP are reproduced in the Joint Appendix at pages 27a-134a.) In the HSP, as "a number one priority for implementation," MAHSA stressed the need to find a solution to the growing surplus of hospital beds in the Kansas City area. (J.A. at 105a). MAHSA found that existing inpatient facilities already were meeting the needs of the community, and that by 1983 the region would have as many as 2,420 surplus beds. (J.A. at 84a-85a; 102a).

The cost of maintaining empty beds was translated into dollars in the Health Systems Plan:

> "A staffed, but unused hospital bed costs the hospital to maintain. . . . The total cost to the community for the projected surplus beds could range from $31,097,150 to as high as $93,484,600 annually by 1983—the equivalent of $22 to $67 per capita in the MAHSA area." (J.A. at 89a).

This lack of use, however, constituted only part of the cost. Efforts by Kansas City hospitals to fill their surplus beds were anticipated by MAHSA to lead to "inappropriate admissions," as well as unnecessarily long stays, resulting in added expense, and, worse, in needless risk to patients:

> "The cost of over-utilization is measured by more than just the cost of the hospital stay. The total cost includes the possibility of increased morbidity [the relative incidence of disease] and mortality in addition to social and emotional costs." (J.A. at 90a).

Significantly, "the use rate and admission rate" in Kansas City "were among the highest in the United States." (J.A. at 89a).

On the basis of these findings, MAHSA determined that it was unnecessary to add to the hospital beds available in the Kansas City area and "publicly declared that it would disapprove the addition of any additional acute care hospital beds." (Pet. Br. at 5).[2]

MAHSA also determined that since the cost of inpatient services was influenced by the "nature of third party reimbursement programs" such as Blue Cross, these programs should "promote appropriate utilization of hospital services." (J.A. at 66a-67a). MAHSA stated that its "Plan should be used by community leaders as a decision making tool for the allocation of local public and private health care resources," recognizing that "without the assistance, involvement and willing participation" of consumers, providers and others, "no Health Systems Plan, no matter the quality, will be implemented." (J.A. at 43a, 40a).

Respondent Blue Cross of Kansas City ("Blue Cross") was one of the participants in MAHSA, with representation on MAHSA's board. Blue Cross is a non-profit organization, organized pursuant to Missouri law and subject to the supervision of the Missouri Director of Insurance.[3] It offers individual and group health care reimbursement plans to the general public in Missouri and Kansas. (Complaint ¶ 4, J.A. at 7a). A majority of its board and its executive committee are representatives of the public, including community, business and labor leaders. (Blue Cross Int. Ans., Exhibit A; D.R. at 270). According to the petitioner, Blue Cross subscribers account for

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2 "Acute care" services include medical/surgical services, obstetrics, pediatrics, and acute psychiatric and alcohol beds. (J.A. at 65a). They do not include long-term services such as those provided by nursing homes. (J.A. at 58a-59a).

3 Mo. Rev. Stat. §§ 354.010 *et seq.*

"approximately one-fourth of all area hospital admissions" in the Kansas City region. (Pet. Br. at 4).[4]

Reimbursement made for hospital services provided to Blue Cross subscribers is paid directly by Blue Cross to hospitals with which Blue Cross has entered into contracts. These are known as "participating hospitals." (Complaint ¶ 13, J.A. at 9a). (When Blue Cross subscribers are treated at other hospitals, the subscriber pays the hospital and Blue Cross reimburses the subscriber at 80 percent of the hospital's charges. *Id.*)

On January 1, 1976, Blue Cross had adopted the following policy for contracting with new hospitals, adhering precisely to the findings of local planning agencies:

> "The hospital must meet a clearly evident need for health care services in its defined service area. *Health care institutions and institutional services shall be approved,* and/or if required by law, certified as necessary, *by the designated planning agency or areawide health planning agency respectively;* or, when effective, by the designated State Agency as provided for in Public Law 93-641, the 'National Health Planning and Resources Development Act of 1974.' " (J.A. at 146a) (emphasis added).

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4 The other respondent, Blue Cross Association ("BCA"), is an Illinois not-for-profit membership corporation to which Blue Cross Plans throughout the United States belong. (BCA Aff., ¶ 2; D.R. at 39). BCA does not do business in Missouri and does not offer health care plans in Missouri or elsewhere; it does not contract with hospitals. (*Id.*, ¶¶ 3, 4, 7; D.R. at 39-40). Blue Cross is a member of BCA, but BCA has neither the power nor the duty to control Blue Cross' contracts with any hospital. (BCA Aff., ¶ 4; BCA Int. Ans., Exhibits E & F; D.R. at 39). The statement of purpose in BCA's Articles of Incorporation specifies that "inherent in [BCA's] purposes is a recognition that State and local Plans are, and should be, autonomous in their operation and that the needs, facilities, resources and practices of the respective areas shall be given due consideration." (BCA Aff., ¶ 3; D.R. at 39). BCA also formulates guidelines to advise the local Plans as to cost containment approaches. (*See* J.A. at 159a-166a).

And, on July 21, 1976, recognizing that Missouri had no state-level planning agency at that time, Blue Cross publicly had announced:

> "Since the State Planning Agency no longer exists, Blue Cross of Kansas City will look to the local Health Systems Agency for approval of . . . capital projects. That Health Systems Agency in the Kansas City metropolitan area is the Mid-America Health Systems Agency. . . . *All projects not reviewed and approved by these Health Systems Agencies will not be reimbursable by Blue Cross of Kansas City.*" (J.A. at 204a).[5]

Disregarding MAHSA's determination in the Health Systems Plan against adding new hospital beds, the petitioner, National Gerimedical Hospital and Gerontology Center ("National Gerimedical"), proceeded to erect a new 120-bed acute care hospital in metropolitan Kansas City. (Complaint ¶ 3, J.A. at 6a). It did not ask MAHSA to reconsider or to make an exception in its case; petitioner neither sought nor received MAHSA's approval. (Pet. Br. at 5).[6]

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5 This policy of Blue Cross was also applicable to projects undertaken by existing hospitals.

6 National Gerimedical took advantage of a unique hiatus which arose for a few years after 1976 when Missouri, which had not yet enacted a state certificate of need law, decided not to renew its contract with HEW under Section 1122 of the Social Security Act. 42 U.S.C. § 1320a-1.

In August 1979 (effective October 1, 1980), Missouri adopted certificate of need legislation, which now effectively bars the construction of new hospitals that have not been approved by the state planning agency. Mo. Ann. Stat. ¶¶ 197.300 *et seq.* (Vernon Supp. 1980). Nationwide, every other state also has passed certificate of need laws restricting construction of unapproved hospitals, except for Louisiana. *See* CHAYET & SONNENREICH, P.C., CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT 155-944 (1978). Accordingly, the opportunity to build an unnecessary hospital was not only short-lived in Missouri, but now has been legislated against in virtually the entire country.

On February 16, 1978, National Gerimedical applied to Blue Cross for a participating hospital contract. (Complaint ¶ 16, J.A. at 10a). Blue Cross adhered to its policy of contracting with new hospitals only if MAHSA had approved the additional facilities and, on March 21, 1978, informed National Gerimedical that its application had been denied. (Complaint ¶ 17, J.A. at 10a). National Gerimedical proceeded to open seven months later, on October 16, 1978. (Pet. Br. at 3).[7]

National Gerimedical brought this suit on May 23, 1978 in the United States District Court for the Western District of Missouri, charging defendants Blue Cross and the Blue Cross Association with conspiring with MAHSA and others to refuse to contract with National Gerimedical, thereby placing that hospital at a competitive disadvantage in violation of Sections 1 and 2 of the Sherman Act. The district judge granted summary judgment, dismissing the complaint on the ground that the Health Planning Act of 1974 impliedly repealed the federal antitrust laws. (J.A. at 171a, 192a). The United States Court of Appeals for the Eighth Circuit unanimously affirmed and denied rehearing. (J.A. at 199a, 217a). National Gerimedical then petitioned this Court for a writ of certiorari, which was granted on January 26, 1981.

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7 Amicus complains that Blue Cross barred the hospital's entry. (S.G. Br. at 13). This is not the case. Having successfully sidestepped the 1974 Act's planning process and erected a 120-bed hospital during the hiatus in Missouri law, petitioner here seeks, with the aid of the antitrust laws, to force Blue Cross to contract to help to pay for those beds.

SUMMARY OF ARGUMENT

The jugular issue is one of congressional intent at the time the Health Planning Act of 1974 was passed; that is, whether Congress intended the actions challenged in this case to be subject to the antitrust laws. Repeal of the antitrust laws should be implied where a subsequently enacted regulatory scheme is irreconcilable with antitrust, and repeal of antitrust is necessary to make the scheme work. *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694 (1975); *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659 (1975).

The intent of Congress in enacting the Health Planning Act of 1974—the legislation relevant to this private case—was shaped by concern over the thousands of excess hospital beds being built in the United States and the failure of classic marketplace forces to prevent or correct the situation. Skyrocketing costs, wasteful duplication of resources and unnecessary capital expenditures presented the chief problems. To view the matter as did the 1974 Congress is to understand that preventing unnecessary duplication of hospital beds was of the highest priority.

Congress responded with comprehensive planning, coordinated by federally designated and funded Health Systems Agencies ("HSAs"). Federally supervised areawide planning was first introduced, on a less ambitious scale, in the mid-1960's. In adopting the Health Planning Act of 1974 Congress confirmed that planning, rather than competition, should allocate the nation's supply of hospital beds to avoid needless and costly duplication.

The HSAs were directed to formulate regional plans and "to implement [these plans] with the assistance of individuals and public and private entities. . . ." 42 U.S.C. § 300*l*-2(c)(1). Cooperative implementation by private entities was basic to the Health Planning Act of 1974, and Congress intended such

implementation to be encouraged. While other approaches for controlling the overbuilding of hospitals developed, including state certificate of need programs, these approaches were complementary to cooperative implementation by private entities, not substitutes for it.

The comprehensive planning mandated for preventing duplication of hospital facilities is the antithesis of competition, and as a consequence, the Health Planning Act of 1974 is at loggerheads with antitrust. Moreover, the cooperative implementation specified by the 1974 Health Planning Act cannot succeed if the private entities which are expected to do the implementing are faced with the conflicting standards of planning and antitrust, and with exposure to antitrust treble damage liability. It was precisely to avoid such results that the doctrine of implied repeal was fashioned, and under the principles of implied repeal articulated in *NASD* and *Gordon,* the antitrust laws must give way.

Here, the very conduct under attack as an antitrust violation is integral to the design of Congress in framing the 1974 Act. Congress required the formulation of Health Systems Plans "preventing unnecessary duplication" and instructed the HSA's "to implement [these plans] with the assistance of individuals and public and private entities. . . ." 42 U.S.C. § 300*l*-2(a)(4), (c)(1). The HSA here determined in its Plan that no additional hospital beds should be opened in the area and called upon insurers such as Blue Cross to implement that Plan. The Complaint charges that "Blue Cross and BCA have combined, contracted and conspired with each other and with co-conspirator MAHSA" and others: "(i) to deny plaintiff hospital Blue Cross Participating Membership . . . and (ii) to limit, restrict and foreclose plaintiff's entry . . . ." (Complaint ¶ 18(e), J.A. at 12a). Thus, the conduct alleged to violate the antitrust laws is the very conduct specified by the 1974 Health Planning Act, and implied repeal is necessary to make the Act work.

It is no answer to say that the conduct here was "unsupervised," because the determination by Blue Cross precisely

followed the determinations of a federally established and funded HSA. Blue Cross adopted no community need standards; it merely followed the decisions made by the HSA. It is also erroneous to suggest that respondents are seeking a "blanket" or "umbrella" exemption. The only issue is whether implied repeal of antitrust under the 1974 Act should be found on the specific facts of this case.

Moreover, inclusion of a liability exemption in the 1974 Act for individuals serving on an HSA does not preclude the finding of an implied repeal under the doctrine of "expressio unius." The exemption had nothing to do with antitrust—the 1974 Congress had no reason to consider antitrust—and implied repeals have been found by this Court despite specific exemptions which did not cover the conduct in question.

The overriding issue here is, necessarily, the congressional intent in the 1974 Act, as applied to the specific facts of this case. That intent of Congress in 1974 was to prevent unnecessary duplication of hospital facilities through planning, relying on cooperative implementation by private parties. Had the 1974 Congress addressed the specific facts of this case, it would have thoroughly approved the action of Blue Cross, which precisely followed the HSA's determination.

ARGUMENT

I.

Congress Intended the Health Planning Act of 1974 to Halt the Overbuilding of Hospital Beds

A. The Problem of Overbedding in 1974

The Health Planning Act of 1974 begins with, and is based on, a congressional finding that "[i]ncreases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary. . . ." 42 U.S.C. § 300k(a)(4). Since this case necessarily turns on the intent of Congress in 1974, it is important to return to the perspective of that year and examine the situation faced by the Congress. Congressional investigation at the time revealed that:

> "Investment in costly health care resources, such as hospital beds . . . is frequently made without regard to the existence of similar facilities or equipment already operating in an area. Investment in costly facilities and equipment not only results in capital accumulation, but establishes an ongoing demand for payment to support those services. There is convincing evidence from many sources that overbuilding of facilities has occurred in many areas, and that maldistribution of high cost service exists." S. Rep. No. 93-1285, 93d Cong., 2d Sess. 39, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7878.

The "ongoing demand for payment" to support excess facilities was causing surplus beds to be filled unnecessarily, either by admitting patients who did not genuinely need to be hospitalized or by holding other patients in hospitals longer than medically warranted. Demand was being artificially inflated to meet supply, encouraging the supply of beds to expand continuously under a sort of medical Parkinson's law, which has become known as Roemer's Law.[8] As described above, this was identified in the MAHSA Health Systems Plan as a particular problem in Kansas City, where usage and admission rates were unusually high. (*See* p.4 *supra*).

Congress found that there would be nearly 67,000 excess hospital beds in this country, according to 1974 estimates. S. Rep. No. 93-1285, 93d Cong., 2d Sess. 24, 42, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7864, 7882. As elaborated in the Senate Report:

> "Hospital beds, though unused, contribute substantial additional costs to the health care industry. It is estimated that a hospital bed, full or empty, costs ⅓ its initial cost each year to operate. Each $1,000 invested in hospital

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8 *See* Shain & Roemer, *Hospital Costs Relate to the Supply of Beds*, 92 Mod. Hospitals 71 (1959); Rogatz, *Excessive Hospitalization Can be Cut Back*, 48 Hospitals 51, 52 (1974).

> expansion requires approximately $333 each year in operational financing." S. Rep. No. 93-1285, 93d Cong., 2d Sess. 39, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7879.

In 1974, it was projected that the total annual expense of supporting excess hospital beds in America would reach between $1 and $2 billion per year. *Id.* at 42, *reprinted at* 7882.

Examining the reasons for this surplus, the Senate Committee found in 1974:

> "The need for strengthened and coordinated planning for personal health services is growing more apparent each day. In the view of the Committee *the health care industry does not respond to classic marketplace forces.* The highly technical nature of medical services together with the growth of third party reimbursement mechanisms act to attenuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's immediate incentive to contain expenditures." *Id.* at 39, *reprinted at* 7878 (emphasis added).

To overcome these factors and end overbedding, Congress enacted the Health Planning Act of 1974.

B. Congress Intended Planning to Prevent Duplication of Health Resources

The purpose and design of the Health Planning Act of 1974 are illuminated when viewed in historical context.

At the conclusion of the Second World War, Congress found that the United States was suffering from a serious shortage of hospital beds resulting from a virtual suspension of hospital building during the Depression and the War. S. Rep. No. 93-1285, 93d Cong., 2d Sess. 19, *reprinted in* [1974] U.S. Code

Cong. & Ad. News 7842, 7859. The House Committee on Interstate and Foreign Commerce concluded that the free market development of hospital services "resulted not in a system of hospital and health facilities, but in a pattern leaving many areas of unmet need." H. Rep. No. 2519, 79th Cong., 2d Sess. 4, *reprinted in* [1946] U.S. Code Cong. & Ad. News 1561. To remedy the situation, Congress enacted the Hill-Burton Program in 1946 to underwrite new hospital construction with federal assistance. *Id.* So much construction was undertaken, however, that by the mid-1960's Congress discovered that too many hospital beds were being built. 110 Cong. Rec. 11790 (1964) (remarks of Rep. Harris); 112 Cong. Rec. 24707 (1966) (remarks of Sen. Kennedy).

To combat this, new legislation was enacted beginning in 1964. The Hospital and Medical Facilities Amendments of 1964, Pub. L. No. 88-443, 78 Stat. 447, and the Comprehensive Health Planning and Public Health Services Amendments of 1966, Pub. L. No. 89-749, 80 Stat. 1180, introduced the concept of federally coordinated regional planning. The 1964 law authorized federal funding for areawide health facilities planning councils to oversee new hospital construction. 78 Stat. at 452 § 604. The 1966 Act, which opened with the declaration that "comprehensive planning for health services . . . is essential" to achievement of national health goals, coordinated both construction and a broader range of health planning through the creation of areawide and state comprehensive health planning ("CHP") agencies. 80 Stat. at 1181 § 2(b).

Meanwhile, in the late 1960's, some states began to experiment with certificate of need laws. These laws restricted new hospital construction unless approved by a specified state agency. In states where such laws were adopted, areawide CHP agencies assumed the additional responsibility of reviewing proposals for new facilities on behalf of the state agencies involved. S. Rep. No. 93-1285, 93d Cong., 2d Sess. 10, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7852.

As for the federal government, in 1972, Congress amended the Social Security Act to prohibit the use of Medicare and Medicaid funds to reimburse health care facilities for costs associated with capital expenditures which did not meet with agency approval. Pub. L. No. 92-603, § 221(a), 86 Stat. 1329 at 1386, codified at 42 U.S.C. § 1320a-1. With this addition, the goals of planning could be achieved in three ways: through cooperative implementation by hospitals, insurers and other providers, which was the chief means of implementation originally contemplated under the 1966 Act (*see* pp. 24-25 *infra*); through the emerging state certificate of need programs; and through the denial of Medicare and Medicaid funding under the Social Security Act.

After several years of operation, the various laws were reviewed by Congress and crystallized into the Health Planning Act of 1974. Pub. L. No. 93-641, 88 Stat. 2225, codified at 42 U.S.C. § 300k *et seq.* Congress sought to build "upon the experience of these programs and . . . to combine their best features into one new health planning and resources development effort." S. Rep. No. 93-1285, 93d Cong., 2d Sess. 5, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7846.

Congress determined in 1974 that "[t]he need for additional hospital beds in the nation [had] virtually disappeared." *Id.* at 24, *reprinted at* 7864. It recognized that competition had been ineffective in the health care sector, and in place of the "classic marketplace forces" which did not work, it framed a new, even more comprehensive "national health planning policy." 42 U.S.C. § 300k(b). The principal actors in the new scheme were the regional, federally designated and funded Health Systems Agencies ("HSAs"). *Id.* at §§ 300*l*-300*l*-5. Each HSA was charged with responsibility for the "provision of effective health planning for its health service area and the promotion of the development within the area of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency." *Id.* at § 300*l*-2(a). Each was also expected to meet the goals of "restraining increases in the cost of providing . . . health

services" and "preventing unnecessary duplication of health resources." *Id.* at § 300*l*-2(a)(3), (4). Nowhere in the 1974 Act was there *any* congressionally stated goal of encouraging competition in the health services field.

To achieve these specified objectives, each HSA was directed to formulate a master Health Systems Plan ("HSP") and Annual Implementation Plans ("AIPs") for its region.[9] 42 U.S.C. at § 300*l*-2(b). An HSP is a detailed statement of goals describing the type of environment and health systems which will assure the area economical, accessible and high quality health services. *Id.* These goals must be responsive to the needs and resources of the area and must be consistent with national guidelines for health planning policy. *Id.*[10]

Furthermore—and most important in this case—Congress stated that:

> "A health systems agency shall implement its HSP and AIP, and *in implementing the plans* it shall perform at least the following functions:
>
> "(1) The agency shall seek, to the extent practicable, *to implement* its HSP and AIP *with the assistance of individuals and public and private entities* in

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9 AIPs are specific yearly objectives for achieving the goals of the HSP. 42 U.S.C. § 300*l*-2(b)(3).

10 Specifically, in promulgating a Health Systems Plan, the HSA is required to assemble and analyze data concerning the status of health and health care in its area; the number, type and location of health care facilities, and the patterns of utilization of these facilities; and the effect of the area's health care delivery system on the health of area residents. 42 U.S.C. § 300*l*-2(b) (1). In formulating its Health Systems Plan, the HSA is required to consider the recommended national guidelines for health planning policy issued by the Secretary of Health and Human Resources, the priorities set forth in the Health Planning Act, and the data which it was required to assemble. 42 U.S.C. § 300*l*-2(b)(2). Before establishing its Health Systems Plan, each HSA is required to conduct a public hearing and give interested persons an opportunity to submit their views orally and in writing. *Id.* All of the activities of the HSA are subject to continuous review by the United States Department of Health and Human Services. 42 U.S.C. § 300*l*-4.

its health service area." *Id.* at § 300*l*-2(c)(1) (emphasis added).[11]

Congress conferred general supervisory authority over the HSAs upon the Secretary of Health, Education and Welfare (now Health and Human Services). The Secretary was required to issue guidelines and goals concerning national health planning policy, 42 U.S.C. § 300k-1, to enter into agreements designating entities as HSAs, and to revoke such designation if an HSA failed to comply with or effectively carry out the provisions of its agreement. *Id.* at § 300*l*-4.

The 1974 Act requires a careful review and extensive scrutiny of any entity before the Secretary can enter into an agreement and thereby designate it as an HSA. The Act contains three requirements which must be met before a conditional designation is made:

> "(A) the entity has submitted an application for such designation which contains assurances satisfactory to the Secretary that upon completion of the period of conditional designation the applicant will be organized and operated in the manner described in section 300*l*-1(b) of this title and will be qualified to perform the functions prescribed by section 300*l*-2 of this title;
>
> "(B) a plan for the orderly assumption and implementation of the functions of a health systems agency has been

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11 Also, in another section, 42 U.S.C. § 300*l*-2(d), Congress provided that:

> "Each health systems agency shall coordinate its activities with—
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> . . .
>
> "(5) any other appropriate entity,
>
> in the health system agency's health service area. The agency shall, as appropriate, secure data from them for use in the agency's planning and development activities, enter into agreements with them which will assure that actions taken by such entities which alter the area's health system will be taken in a manner which is consistent with the HSP and the AIP in effect for the area, and, to the extent practicable, provide technical assistance to such entities."

received from the applicant and approved by the Secretary; and

"(C) the Secretary has consulted with the Governor of each State in which such health service area is located and with such other State and local officials as he may deem appropriate with respect to such designation." *Id.* at § 300*l*-4(b)(4).

At the state level, the 1974 Act provided, in *another* section, for the designation of State Health Planning and Development Agencies ("SHPDAs") to develop state health plans in coordination with Statewide Health Coordinating Councils and to administer state certificate of need programs, where they existed, under guidance from the HSAs. *Id.* at § 300m-300m-5. (The relevance here of state certificate of need programs is discussed *infra* at pp. 28-30.)

What Congress accomplished in the Health Planning Act of 1974 was the creation of a comprehensive mechanism to prevent duplication in the allocation of this nation's health care resources through coordinated planning.

C. Reliance by the Solicitor General on the History and Language of the 1979 Act Is Misplaced

The brief for the United States, as *amicus curiae,* attempts to obscure the issue in this case—the intent of the 1974 Health Planning Act—by focusing instead on the 1979 Act, Pub. L. No. 96-79, 93 Stat. 592, adopted after this case arose, and, therefore, not applicable here. Rather than conducting its analysis from the perspective of 1974, as it must on the facts of this case, the Solicitor General relies on language from the 1979 Act, which he properly notes is "the only statutory language that specifically refers to competition." (S.G. Br. at 16-17).

The Solicitor General's reliance on the 1979 Act is erroneous on two grounds. First, the issue here is the intent of Congress in the 1974 Act, not in the 1979 Act. Second, even if, for the

sake of argument, the 1979 Act is considered relevant, it clearly supports, both on its face and in the accompanying debates and reports, *respondents'* position that in 1974 Congress intended planning, not competition, to allocate the supply of inpatient hospital services. The language and legislative history of the 1979 Act confirm that the 1974 Act was irreconcilable with competition.

At the time the 1979 Act was being considered, concern was expressed in Congress that, in the case of health programs in which providers of care are prepaid for services furnished to enrollees, notably Health Maintenance Organizations ("HMOs"), and in the case of *outpatient* facilities,[12] competitive forces could work. Congress was therefore willing in 1979 to promote competition—*a new concept*—for such programs. In discussing the proposed 1979 Act, Representative Gramm, a member of the Subcommittee on Health and the Environment, expanded on this dichotomy:

> "One of the most important *innovations* is the *creation of competition* in the health care market. We tolerate planning in the health care market, because we have a system which, because of third-party payments, makes the buyer nonprice conscious. This, therefore, creates, on the supply side, nonprice competition, nonconcern about duplication and expense. *We, therefore, have imposed a comprehensive set of controls to prevent duplication.*
>
> "One of the most important things that we have done in these amendments is to recognize that *in a prepaid plan,* whether it is an HMO or simply a vendor of care who is licensed by a State and selling on a prepaid basis, once he sells a contract to provide a service, all of our standard market forces work in his case and, therefore, there is no reason to control him. There is no justification for limit-

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12 "The term 'outpatient facility' means a health facility which offers a reasonably full range of diagnostic and treatment services, not including bed and board." S. Rep. No. 93-1285, 93d Cong., 2d Sess. 59, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7898.

> ing his access to equipment and capital and, under these amendments, we help promote *in this area, which has been devoid of competitive forces in the past, a new competition* which can give us the vehicle to some day let free enterprise work again in the health care market." 125 Cong. Rec. H6219 (daily ed. July 19, 1979) (emphasis added).

Representative Waxman, the Chairman of the Subcommittee, referred to Representative Gramm's proposal in 1979 to exempt HMOs from planning approval (now 42 U.S.C. § 300m-6(b)), and remarked:

> "It is, I think *a new thrust* in the approach to health planning, and . . . an indication of *desire . . . to develop some competition,* some market forces in the health care system where so few are now present." 125 Cong. Rec. H6219 (daily ed. July 19, 1979) (emphasis added).

Thus, in drafting the 1979 Act, Congress drew a clear distinction between inpatient services and prepaid or outpatient services. It fashioned a general provision, now 42 U.S.C. § 300k-2(b), which, in its three paragraphs, introduced encouragement of competition, where it could work, for HMOs and outpatient programs. At the same time, in 1979 Congress explicitly left undisturbed its previous displacement of competition for *inpatient* hospital services in the 1974 Act.

The first paragraph of section 300k-2(b) of the 1979 Act is Congress' finding on the effect of competition:

> "(1) The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished. The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, *particularly for inpatient health services* and other institutional health services. *As a result, there is*

duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services." 42 U.S.C. § 300k-2(b)(1) (emphasis added).

The second and third paragraphs of section 300k-2(b) of the 1979 Act deliberately distinguish between services where competition should *not* be encouraged, specifically including *inpatient* services, and services where competition should be encouraged:

> "(2) For health services, *such as inpatient health services* and other institutional health services, *for which competition does not or will not appropriately allocate supply* consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies *should* in the exercise of their functions under this subchapter *take actions* (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of this subchapter) *to allocate the supply of such services."*
>
> "(3) For the health services *for which competition appropriately allocates supply* consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the performance of their functions under this subchapter give priority (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access) to actions which would strengthen the effect of competition on the supply of such services."

42 U.S.C. § 300k-2(b)(2), (3) (emphasis added).

The *amicus* brief of the Solicitor General, in asserting that Congress "did not foreclose competition in [the] institutional setting *if* competition is in fact found to be working" (S.G. Br. at 20) (emphasis added), fails to recognize that Congress

specifically found in 1974, and again in 1979 (although the 1979 finding is not relevant to this case), that free competition in inpatient services was *not* working. While it is true that in 1979 Congress recognized that the day might come when inpatient services could be allocated by competition, it was abundantly clear in 1974 and 1979 that competition among inpatient facilities at each of those times was counter to the public interest.[13]

The *amicus* brief also overlooks the very specific instructions of Congress in 1979 that, in the case of inpatient services, planning bodies "should" displace competition and allocate supply themselves. 42 U.S.C. § 300k-2(b)(2). As stated in the Conference Reports accompanying the 1979 Act, the findings of Congress "make it clear that for health services, such as inpatient health services and other institutional health services for which competition does not or will not appropriately allocate supply consistent with the plans of the health planning agencies, *the agencies should perform their functions to allocate the supply of those services* . . . ." S. Rep. No. 96-309, 96th Cong., 1st Sess. 58 (1979); H. R. Rep. No. 96-420, 96th Cong., 1st Sess. 58, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1422, 1425 (emphasis added).[14]

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13 Similarly, all the material cited by petitioner (Pet. Br. at 11-12 n.10, 38) for the proposition that commentators and legislators *recently* "have begun to advocate increased reliance on market forces," postdates the 1974 Act and either is limited to prepaid or outpatient programs or is premised on total restructuring of the present system of reimbursement to attempt to create classic marketplace forces. Most of these proposals can be traced to the "Chicago School" of economics, whose laissez-faire theory obviously was not the philosophical underpinning of the 1974 Health Planning Act's approach to inpatient hospital facilities. Since petitioner's hospital does not operate on a prepaid basis, and since Congress developed health planning in 1974 on the premise that the current means of third party reimbursement would continue to exist, the proposals cited by petitioner are of only theoretical interest for present purposes.

14 Indeed, as if to underscore the rejection of competition for inpatient hospital services, the 1979 Act stressed the "identification and discontinuance of duplicative or unneeded services and facilities," 42 U.S.C. § 300k-2(a)(12), and included a section authorizing federal grants for

Similarly, the Solicitor General's assertion that "[t]here is no indication that the later Congress believed that its predecessor had rejected competition and the antitrust laws in the health care field," is incorrect. (S.G. Br. at 17 n.14). Both the language of section 300k-2(b) itself and the Conference Reports in 1979 belie such a contention. Moreover, the remarks made on the floor of Congress by Representatives Gramm and Waxman are exactly to the contrary. *See* pp. 18-19 *supra.*

Furthermore, in the 1978 debates concerning amendment of the Health Planning Act of 1974,[15] Representative Paul Rogers, Chairman of the Subcommittee on Health and the Environment, both then *and in 1974,*[16] described the congressional intent of 1974 to override the antitrust laws where there is implementation by private entities. Although petitioner and the Solicitor General characterize Mr. Rogers' remarks disparagingly, it should be noted that Mr. Rogers for many years was "Mr. Health" in the Congress. He was the principal author of the 1974 Act. As Committee chairman, principal author and floor manager, he had more familiarity with this law than any other individual.[17] Mr. Rogers' statements merit particular attention:

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the purpose of paying hospitals *to close down.* 42 U.S.C. §§ 300t-11-300t-14. These provisions establish a mechanism whereby HSAs are instructed to identify excess facilities in their area and assist in converting them to other uses or discontinuing them, using the funding made available as an incentive to ease the impact of such closings.

15 In 1978 a health planning bill was passed by the Senate but not acted on by the House in time to be voted on before Congress adjourned. *See* S. Rep. No. 96-96, 96th Cong., 1st Sess. 48, *reprinted in* [1979] U.S. CODE CONG. & AD. NEWS 1306, 1353.

16 Representative Waxman succeeded Representative Rogers as chairman in 1979.

17 The cases cited by petitioner and the Solicitor General regarding post-enactment remarks by Congress bear no relationship to this situation. (Pet. Br. at 21-22 n.17; S.G. Br. at 18-19 n.15). *See* United States v. United Mine Workers, 330 U.S. 258, 282 (1947) (remarks were made eleven years after passage of the relevant statute by certain senators, some of whom had not been members of the Senate at the time of passage, and none of whom had been on the committee which

"Although Public Law 93-641 [the Health Planning Act of 1974] contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. *The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, Public Law 93-641 simply could not be implemented.*" 124 Cong. Rec. H11,962-11,963 (daily ed. Oct. 10, 1978) (emphasis added).[18]

Thus, Congress left no doubt in 1979 that planning, not competition or antitrust, should continue to allocate the supply

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reported the bill); United States v. Philadelphia National Bank, 374 U.S. 321, 343-49 (1963) (post-enactment statements conflicted with statements made at the time of passage of the relevant statute); Regional Rail Reorganization Cases, 419 U.S. 102, 132 (1974) (same). Neither petitioner nor the Solicitor General has cited *any* legislative history from 1974 which conflicts with Mr. Rogers' statements.

Moreover, contrary to petitioner's assertion (Pet. Br. at 21-22 n.17), this Court has recognized that post-enactment statements may properly be consulted where they shed light on Congress' intent. *See* Andrus v. Shell Oil Co., 446 U.S. 657, 666 n.8, 668-71 (1980); Nashville Milk Co. v. Carnation Co., 355 U.S. 373, 382 (1958) (post-enactment remarks of Representative Patman, "epitomizing the conclusions to be drawn from the legislative history" of the Robinson-Patman Act). As the principal architect of health planning legislation, and its closest congressional student, Mr. Rogers was uniquely qualified to evaluate the ruinous impact antitrust liability would have had on the cooperative system between providers and HSAs that Congress had erected. Mr. Rogers is certainly more authoritative than the law review commentary cited by petitioner. (Pet. Br. at 38).

18 Petitioner and the Solicitor General also have argued that Representative Rogers' remarks are inapposite because he was not referring to the specific factual situation presented in this case. When the remarks are read in full context, however, it becomes clear that Representative Rogers referred to hospitals only as an "example" of provider cooperation and referred to the interaction of the Health Planning Act of 1974 and certificate of need legislation as only one indication of Congress' intent that there be an implied repeal of antitrust. It is noteworthy that the 1974 Act clearly defined "provider" to include insurers such as Blue Cross. 42 U.S.C. § 300*l*-1(b)(3)(C)(ii)(III).

of inpatient hospital services, and that this had been the intent also in 1974. In 1974, the chief concern of Congress had been elimination of overbedding through planning—and there was not a hint of competition or antitrust intruding upon the planning process. In 1979, competition became a consideration for some programs, but even then competition did not become part of the statutory design for inpatient services.

The Solicitor General here is substituting what he now believes Congress *should* have done in 1974, not what Congress actually did. Also, it may be noted, nowhere in the 1974 congressional proceedings was this "pro-competition" position advanced by the Department of Justice.

The legislative record amply demonstrates that congressional intent in the Health Planning Act of 1974 did not embrace competition for inpatient facilities such as those of the petitioner hospital.

II. Congress Intended to Implement the Health Planning Act of 1974 Through Cooperation by Private Entities

A. Cooperation by Private Entities in Implementing the Health Systems Plan Was Essential to the Statutory Scheme

Implementation of health planning by private entities such as hospitals and insurers has long been important to federal health planning. The 1966 Act opened with a declaration that attainment of the highest possible level of health care "depends on an *effective partnership,* involving . . . official and *voluntary* efforts, and *participation of individuals and organizations.*" Pub. L. No. 89-749, § 2, 80 Stat. 1180, § 2 (emphasis added).[19] This "partnership" took various forms. For example,

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19 The 1966 Act also stressed that the planning which each state was expected to undertake individually had to "provide for encouraging cooperative efforts among governmental or nongovernmental agencies, organizations, and groups concerned with health agencies, facilities, or manpower. . . . " Pub. L. No. 89-749, 80 Stat. 1180, at 1181 § 3(a)(2)(D), codified at 42 U.S.C. § 246(a)(2)(D).

among the measures instituted by the areawide comprehensive health planning agencies created under the 1966 Act were voluntary moratoriums on new hospital construction, which were agreed to by providers in a number of cities "[f]aced with rapidly growing supplies of hospital beds." S. Rep. No. 93-1285, 93d Cong., 2d Sess. 11, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7852. One of these was Kansas City itself, where a cooperative moratorium had served to prevent the construction of unneeded hospital beds prior to passage of the Health Planning Act of 1974. *Id.* Significantly, this program was applauded by the Senate in 1974. *Id.* Had Congress intended to subject to the antitrust laws the actions of providers who carry out an HSA determination, it would hardly have singled out for commendation a "cooperative moratorium" that, in antitrust terms, would be regarded as an anticompetitive cartel.

When it came to the Health Planning Act of 1974, Congress was even more explicit. First, it established the HSAs and required participation by both consumers (in the majority) and providers, including insurers such as Blue Cross. Second, it charged each HSA with formulating a Health Systems Plan to guide all health care entities in its region.

But that was not all. Congress demonstrated that it intended more than just promulgation of a Health Systems Plan by the HSA, directing that "[t]he agency shall seek, to the extent practicable, *to implement* its [Health Systems Plan] . . . *with the assistance of individuals and public and private entities* in its health service area." 42 U.S.C. § 300*l*-2(c)(1) (emphasis added).[20] As stated in the Senate Report: "A health planning agency is directed to seek to implement its long-range goal plan and short-term priorities plan with the assistance of individuals and public and private entities in its health area." S. Rep. No.

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20 While petitioner emphasizes the words "to the extent practicable" (Pet. Br. at 20), this merely signifies that since implementation by private entities is based on cooperation, not compulsion, there may be limits to the implementation the HSAs are able to expect from them.

93-1285, 93d Cong., 2d Sess. 49, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7888.

As later described by Representative Dr. Tim Lee Carter, one of the authors of the 1974 Act, health planning is a special species of regulation:

> "This is not regulation in the style of an Interstate Commerce Commission or a Food and Drug Administration; *health planning is a cooperative system* which provides an opportunity for all of the actors in the health care scene to participate in the decision making process." 125 Cong. Rec. H6212 (daily ed. July 19, 1979) (emphasis added).

The hub of this cooperation is the HSA. As noted earlier, each HSA has a broad-based governing body composed of consumers of health care *and* "providers," including hospitals and third-party payers such as Blue Cross Plans. 42 U.S.C. § 300*l*-1(b)(3)(C). The active involvement of providers is assured through the Act's requirement that between forty and forty-nine percent of the members of each HSA governing body be providers of health care. *Id.* at § 300*l*-1(b)(3)(C)(ii). Congress mandated that since the provider is "one of the most important participants" in the health care sector, "it is *imperative* that the provider be encouraged to play an active role in developing health policy *at all levels.*" *Id.* at § 300k(a)(5) (emphasis added).

Providers, then, in the first instance, participate in formulating the Health Systems Plan ("HSP"). The HSP is meant to serve as a blueprint for future development of all health services in the HSA's area, furnishing a "public statement of the community's goals and objectives." S. Rep. 96-96, 96th Cong., 1st Sess. 37, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1342. The HSP is "intended to form the foundation upon which the entire health planning process would be built." *Id.* at 63, *reprinted at* 1368. As explained by MAHSA, "The Plan should be used by community leaders as a

decision making tool for the allocation of local public and private health care resources." (J.A. at 43a).

MAHSA recognized that the cost of inpatient services was influenced by the "nature of third party reimbursement programs" and accordingly concluded that its plans for containing inpatient costs should "require that . . . [t]he reimbursement system promote appropriate utilization of hospital services. . . ." (J.A. at 66a-67a).[21] Emphasizing the importance of such implementation, the MAHSA Health Systems Plan included the following appraisal:

> "The Agency realizes that without the assistance, involvement and willing participation of consumers, providers, elected officials and other community leaders, no Health Systems Plan, no matter the quality, will be implemented." (J.A. at 40a).

Consistent with this, Blue Cross' criteria for contracting with hospitals required that "health care institutions and institutional services shall be approved . . . by the . . . area-wide health planning agency." (J.A. at 146a). This policy did no more than incorporate MAHSA's policy. It created no standards and authorized no judgments of Blue Cross' own; rather, Blue Cross embraced the standards and adopted the judgments of the HSA *in toto*. Indeed, what else could Blue Cross have done? Its only alternative was to flout the express objectives of the Health Planning Act of 1974 and undermine MAHSA's Health Systems Plan, rather than "implement" it.

The illogic of petitioner's cause of action is highlighted by comparing the language of the 1974 Act with the allegations of the Complaint. The Act instructs the HSA to prevent "unnecessary duplication," 42 U.S.C. § 300*l*-2(a)(4), and "to implement its HSP. . . with the assistance of individuals and public

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21 Petitioner's assertion that "the only provisions of the MAHSA Plan dealing specifically with third-party payers relate to the development of uniform reporting systems and procedures" is erroneous. (Pet. Br. at 38 n.35).

and private entities." 42 U.S.C. § 300*l*-2(c)(1). The Complaint alleges:

> "Defendants Blue Cross and BCA have combined, contracted and conspired with each other and with co-conspirator MAHSA; with each other and with co-conspirators Gary L. Ihde and Elias E. Zirul, acting in their capacities as an officer and members of the board of MAHSA; and with each other and with co-conspirators Earl E. Horton and Independence Sanitarium and Hospital, acting on behalf of and representing the interests of area hospital competitors of plaintiff, (i) to deny plaintiff hospital Blue Cross Participating Membership thereby foreclosing plaintiff's access to a significant portion of the health care services market, and (ii) to limit, restrict and foreclose plaintiff's entry into the health care services market as a health care provider on an equal basis with competitor area hospitals." (Complaint ¶ 18(e), J.A. at 12a).

Petitioner's claim is that by doing exactly what was intended by the Health Planning Act of 1974—by implementing the MAHSA Health Systems Plan—Blue Cross could violate the antitrust laws. The clear repugnancy between the two statutory schemes is brought into sharp focus by nothing so well as this very claim.

B. The Enactment of State Certificate of Need Legislation Did Not Supplant Implementation Through Cooperation by Private Entities

A second avenue for effectuating the goals of health planning opened up in the late 1960's and early 1970's through state certificate of need programs. These programs continued under and were incorporated into the Health Planning Act of 1974. They were to be administered by a state health planning and development agency ("SHPDA"), which was made responsible for statewide planning under the guidance of the regional HSAs. 42 U.S.C. § 300m-2(a)(4)(B). For the first time, the

1974 Act made state adoption of prescribed certificate of need programs a prerequisite for federal health funding. This eventually encouraged every state, except Louisiana, to adopt such a law.[22] Since certificate of need laws are required to "provide for procedures and penalties" for enforcement in order to meet federal standards, 42 U.S.C. § 300m-2(a)(4)(B), they have proved to be effective in preventing the construction of unneeded hospitals and therefore have attracted considerable attention in recent years. But they did not extinguish the other means of health planning for inpatient hospital facilities, including cooperative implementation by providers such as Blue Cross. *See* pp. 24-28 *supra*.

Petitioner, however, asserts that under the Health Planning Act of 1974, "an HSA's *sole* function with respect to new hospital construction is to advise state health agencies" with regard to effectuating state certificate of need programs. (Pet. Br. at 4) (emphasis added); (*cf.* S.G. Br. at 13). This is not so. Petitioner's argument is based on the contention that because, between June 30, 1976 and the later passage of Missouri's certificate of need law (effective October 1, 1980), Missouri had no state certificate of need legislation, the Health Planning Act and MAHSA were serving no regulatory function in Missouri at that time at all. Missouri's delay, however, did not detract from the applicability of the Health Planning Act of 1974, from cooperative implementation by providers, or from the duties of the HSAs operating in that state, including reduction of "documented inefficiencies" and implementation of their Health Systems Plans. 42 U.S.C. § 300*l*-2(a). It did not mean that there was no "federal regulatory scheme" (Pet. Br. at 25), but only that there was no *state* involvement in the scheme. Petitioner cannot escape the provisions of the 1974 Act merely because the State of Missouri hesitated in enacting its own legislation.[23] If the petitioner were correct, MAHSA's

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22 *See* note 6 *supra*.

23 The Court of Appeals pointedly disposed of this argument, saying that petitioner's "emphasis upon the fact that Missouri was not a participating state . . . misses the focus of the doctrine of implied

formulation of a Health Systems Plan for Missouri would have been nothing but an idle exercise and the references to "implementation" in the 1974 Act would have been meaningless.

The Health Planning Act of 1974 provides *two* tracks for implementation. One section of the Act calls for private, cooperative implementation, instructing the HSA "to implement" its Health Systems Plan with the assistance of private entities. 42 U.S.C. § 300*l*-2(c)(1). *Another* section of the Act instructs the HSA "[t]o assist" SHPDAs in carrying out their functions under state certificate of need programs. 42 U.S.C. § 300*l*-2(F).[24]

There are two different sections. There are two different ways to achieve the objective of Congress—to stop duplication of inpatient facilities.

In fact, the certificate of need concept was not immediately embraced by all the states. In 1974 only 24 states had adopted certificate of need laws. 120 Cong. Rec. 37213 (1974). It was not until *after* passage of the 1974 Act that certificate of need legislation was required for federal funding, and even then, the remaining states were allowed the time necessary to put these laws into effect. Thus, among other things, implementation of Health Systems Plans was necessary, apart from certificate of need legislation, during the anticipated hiatus in many states. Although certificate of need programs assumed increasing significance, cooperative implementation remained an important feature of the Act.[25]

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immunity. The doctrine should not be confused with the state action exemption to the antitrust laws as articulated in Parker v. Brown, 317 U.S. 341 (1943)." (J.A. at 206a; *see also* J.A. at 207a).

24 The dictionary defines "implement" as "to carry out" and "to give practical effect to and ensure of actual fulfillment by concrete measures." It defines "assist" as "to give support or aid" and to "help." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 132, 1134 (1971).

25 In a related argument, petitioner erroneously asserts that because Congress at one time considered a specific provision involving insurance reimbursement and decided to enact a different, stronger provi-

In sum, the Health Planning Act of 1974 was the product of a congressional resolve to control inflation in health care by preventing unnecessary duplication of hospital facilities through comprehensive planning by federally designated and funded regional agencies. Congress placed reliance for effectuation of this planning, in part, on implementation by private parties. What emerges is that in 1974 Congress intended (1) to halt unnecessary duplication of inpatient hospital facilities; (2) to substitute planning for competition as the means to reach that end; (3) to encourage private implementation of planning, in addition to relying on state certificate of need mechanisms; and, necessarily, (4) to preclude antitrust from interfering with this scheme.

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sion instead, it could not have intended to immunize this action taken by a private insurer. (Pet. Br. at 21, 37 n.33).

In 1974, when state certificate of need approval was being made a prerequisite to federal funding (*see* pp. 28-29 *supra*), there was a proposal in Congress to provide an alternative. States would have been permitted *either* to establish certificate of need mechanisms *or* to adopt laws forbidding third-party insurers from reimbursing unneeded services. Third-party insurers had cooperated with local planning agencies in formulating their reimbursement policies for years, as Congress was aware. *See* National Health Planning and Development Act, 1974: Hearings on S. 2994, S. 3139, S. 2796 and Related Bills Before the Subcommittee on Health of the Committee on Labor and Public Welfare, 93d Cong., 2d Sess. 542, 545, 586, 588, Part 2 (1974) (statement of D. Eugene Sibery).

Since not all patients are subscribers to third-party insurance plans, however, this would not have been as airtight a deterrent to duplication of facilities as certificate of need requirements. As ultimately passed, the 1974 Act only gives the states the option of enacting certificate of need laws or foregoing federal assistance.

Petitioner's footnote contention that BCA "had attempted to convince the Congress that it should legitimize the very conduct under attack here," at the 1974 hearings is a considerable distortion. (Pet. Br. at 33 n.29). A witness for BCA merely testified that the policy of many Blue Cross Plans not to contract with hospitals which violate planning guidelines could serve as a model for federal financing. Congress in no way rejected this practice, but opted in the 1974 Act for an *even tighter* prerequisite for federal funding in the form of certificate of need laws.

III. Repeal of the Antitrust Laws Should Be Implied in the Circumstances of this Case Because of the Irreconcilable Conflict Between Anticompetitive Inpatient Hospital Planning and Competition

The fulcrum of petitioner's case is the principle that "the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress." *Northern Pacific Railway Co.* v. *United States,* 356 U.S. 1, 4 (1958). (Pet. Br. at 15). In fact, Congress in 1974 found exactly the opposite: that the unrestrained interaction of competitive forces for inpatient hospital services does *not* serve the public interest and should *not* be encouraged because "the health care industry does not respond to classic marketplace forces." S. Rep. No. 93-1285, 93d Cong., 2d Sess. 39, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7878. The conclusion of Congress in 1974 was that the last thing this country needed was "competition" in the form of building more duplicative hospital beds. *See* pp. 10-17 *supra.*

The decisions of this Court establish that where there is repugnancy between the antitrust laws and other, later enacted statutory schemes—where repeal of antitrust is necessary to make the other statutory scheme work—repeal of the antitrust laws will be implied. *United States* v. *National Association of Securities Dealers, Inc.,* 422 U.S. 694 (1975); *Gordon* v. *New York Stock Exchange, Inc.,* 422 U.S. 659 (1975).

In *National Association of Securities Dealers,* the Government unsuccessfully challenged as violations of the Sherman Act practices of mutual funds, underwriters, broker-dealers, and the National Association of Securities Dealers ("NASD") designed to prevent development of a secondary market in mutual fund shares. NASD was registered as an association of securities dealers pursuant to the Maloney Act of 1938, which provides for "a system of cooperative self-regulation through voluntary associations. . . ." 422 U.S. at 701 n.6. Under the Investment Company Act of 1940, NASD was given certain

supervisory powers over mutual funds, and the legislative history of the Act demonstrated that Congress disapproved of the development of a mutual fund secondary market. Consistent with that finding, NASD and the other defendants entered into various agreements between parties at different levels, and among the dealers at the same level, which effectively prohibited the development of a secondary market. The Government claimed that these amounted to both vertical and horizontal conspiracies in restraint of trade, illegal under the antitrust laws.

Addressing the vertical conspiracy charges first, this Court rejected defendants' claim that there was an express exemption for their conduct under Section 22(d) of the Investment Company Act,[26] but went on to find an implied repeal of antitrust on the basis of Section 22(f). 422 U.S. at 720-22. That section permitted mutual funds to restrict the transferability of their shares so long as such restrictions conformed to disclosures in the funds' registration statements and did not contravene any rules which the Securities and Exchange Commission might prescribe. The transfer restrictions at issue in *NASD* conformed to registration statement disclosures. The SEC had not prescribed any rules on the subject at all.

The Government argued that there was no repugnancy between Section 22(f) and the antitrust laws because the SEC had never exercised its power to regulate. This Court found that such exercise was unnecessary:

> "Our examination of the language and history of § 22(f) persuades us . . . that the agreements challenged . . . are among the kinds of restrictions Congress contemplated when it enacted that section. And this conclusion necessarily leads to a determination that they are immune from liability under the Sherman Act, for we see

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26 Section 22(d) provides that "no dealer shall sell [mutual-fund shares] to any person except a dealer, a principal underwriter, or the issuer, except at a current public offering price described in the prospectus." 15 U.S.C. § 80a-22(d).

> no way to reconcile the Commission's power to authorize these restrictions with the competing mandate of the antitrust laws." 422 U.S. at 721-22.

The Court observed that normally the challenged restrictions would amount to concerted refusals to deal and resale price maintenance agreements in violation of the Sherman Act, but held that:

> "In this instance the antitrust laws must give way if the regulatory scheme established by the Investment Company Act is to work." *Id.* at 729-30.

Turning to the horizontal conspiracy charges, the Court explained that the private agreement among NASD and its member broker-dealers not to participate in a secondary market was "*neither required* by § 22(d) *nor authorized* under § 22(f)." 422 U.S. at 730 (emphasis added). As the Government alleged, it was "designed to encourage the suppression of intrafund secondary market activities." *Id.* at 733. But the Court pointed out that this was "precisely the restriction that the SEC consistently has approved pursuant to § 22(f) for nearly 35 years. This close relationship is fatal to the Government's complaint. . . ." *Id.* The Court concluded:

> "Here implied repeal of the antitrust laws is 'necessary to make the [regulatory scheme] work.' *Silver* v. *New York Stock Exchange,* 373 U.S. at 357. In generally similar situations, we have implied immunity in particular and discrete instances to assure that the federal agency entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws. See *Hughes Tool Co.* v. *Trans World Airlines,* 409 U.S. 363 (1973); *Pan American World Airways, Inc.* v. *United States,* 371 U.S. 296 (1963). In this instance, maintenance of an antitrust action for activities so directly related to the SEC's responsibilities poses a substantial danger that appellees

would be subjected to duplicative and inconsistent standards. This is hardly a result that Congress would have mandated." *Id.* at 734-35.

Likewise, in the present case, the conduct of Blue Cross, precisely implementing the determination of MAHSA against new hospital construction, is "directly related" to the responsibility for "preventing unnecessary duplication of health resources" which is at the heart of the Health Planning Act of 1974. Similarly, exposure of Blue Cross to liability for its cooperation with the MAHSA determination also is "hardly a result that Congress would have mandated."

It is no answer to say that Blue Cross was not "compelled" to honor MAHSA's determination. (Pet. Br. at 26; S.G. Br. at 12-13). The Health Planning Act of 1974 is built on "implementation" by entities such as Blue Cross. To require compulsion as a prerequisite to antitrust immunity here would be to destroy the chances for any regulatory scheme based on cooperative implementation ever to succeed.[27] In *NASD* the

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27 The concept of compulsion developed in cases arising under the "state action" doctrine, where the intent of one sovereign (the state) to regulate had to be measured against the intent of a second sovereign (the United States) to apply antitrust. *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, 790-91 (1975). The state action doctrine is not truly an "exemption" at all, but a shorthand expression of the fact that Congress never intended antitrust to apply to certain types of state regulation. City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 393 n.8 (1978).

For implied repeal, where the same sovereign has adopted both the regulatory scheme and the antitrust laws, a congressional intent to repeal antitrust can be implied irrespective of compulsion—as it was in *NASD* and *Gordon*. Indeed, there is some question whether compulsion remains a requirement for applying state action immunity after this Court's decision in California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980), which established a test of clear articulation and affirmative expression of a restraint as state policy, coupled with active supervision. In any event, the test for reconciling the intentions of two sovereigns is not the test applicable for judging whether one Congress intended to limit the legislation of an earlier Congress. Petitioner's reliance on state action cases is incorrect. (Pet. Br. at 28).

alleged vertical conspiracy was not required by the SEC. And the alleged horizontal conspiracy was neither authorized nor required. As this Court pointed out, agreement among the dealers and NASD was "ancillary" to the vertical restraints and subject to the regulatory scheme, and therefore immune from antitrust. 422 U.S. at 734. Like the SEC, MAHSA was in a position to change the action of Blue Cross, by changing MAHSA's determination and finding a need for petitioner to build its hospital. This would have led to approval, as a matter of course, by Blue Cross.

Gordon v. *New York Stock Exchange, Inc.*, 422 U.S. 659, 689 (1975), also bears on this point. In *Gordon*, the New York Stock Exchange and two of its member-brokers were charged with price-fixing for establishing and adhering to fixed commission rates as authorized, but not required, by the Securities and Exchange Commission. The United States, as *amicus*, argued there that if the Exchange had been *ordered* by the SEC to charge fixed commissions, antitrust immunity should attach, but since the SEC had only studied and approved the use of fixed commissions, which the Exchange had adopted by choice, immunity should be denied. This argument was rejected by this Court:

> "We believe that this degree of scrutiny and approval by the SEC is not significantly different for our purposes here than an affirmative order to the exchanges to follow fixed rates. . . . We conclude that immunity should not rest on the existence of a formal order by the SEC, but that the actions taken by the SEC pursuant to § 19(b)(9) . . . are to be viewed as having an effect equivalent to that of a formal order." 422 U.S. at 689 n.13.

Petitioner similarly asserts that MAHSA, like the SEC, "never requested Blue Cross to undertake its action." (Pet. Br. at 37-38). But such a request would have been redundant. The MAHSA Plan, in 1977, already called on reimbursers to "promote appropriate utilization" of inpatient services. (*See* p. 4 *supra*). And Blue Cross, which was represented on the MAHSA board, previously had adopted a requirement in 1976

that new hospitals "shall be approved . . . by the designated planning agency." (*See* p. 5 *supra*). Nothing in the Health Planning Act of 1974 required any more formal arrangement than this—and petitioner considered it sufficiently concrete to label it a conspiracy. (*See* p. 28 *supra*).

The root of the matter is that the 1974 Act and the antitrust laws are inimical to one another and establish conflicting standards. In *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659 (1975), this Court held:

> "We agree . . . that to deny antitrust immunity with respect to commission rates would be to subject the exchanges and their members to conflicting standards. It is clear . . . that the commission rate practices of the exchanges have been subjected to the scrutiny and approval of the SEC. If antitrust courts were to impose different standards or requirements, the exchanges might find themselves unable to proceed without violation of the mandate of the courts or of the SEC. Such different standards are likely to result because the sole aim of antitrust legislation is to protect competition, whereas the SEC must consider, in addition, the economic health of the investors, the exchanges, and the securities industry. Given the expertise of the SEC, the confidence the Congress has placed in the agency, and the active roles the SEC and the Congress have taken, *permitting courts throughout the country to conduct their own antitrust proceedings would conflict with the regulatory scheme authorized by Congress rather than supplement that scheme.*" 422 U.S. at 689-90 (footnotes omitted; emphasis added).

Here, Blue Cross would face, in the words of *Gordon* and *National Association of Securities Dealers,* the "conflicting" and "inconsistent" standards of planning and antitrust if the antitrust laws were to apply.

There are two important national policies in direct conflict here: "the policy unequivocally laid down by the [Sherman]

Act is competition," *Northern Pacific Railway Co.* v. *United States,* 356 U.S. 1, 4 (1958); the policy unequivocally laid down by the Health Planning Act of 1974 is the anticompetitive aim of "preventing unnecessary duplication" of hospital beds through planning. 42 U.S.C. § 300*l*-2(a)(4).[28] Economic planning is the antithesis of competition; the Health Planning Act of 1974 is the antithesis of the Sherman Act in the circumstances of this case. The planning mandated for inpatient hospital facilities is so antagonistic to the antitrust laws that the two are plainly "repugnant" to one another.

Furthermore, congressional reliance in the Health Planning Act of 1974 on implementation by insurers and other providers would be frustrated by the threat of antitrust liability. (*See* pp. 24-28 *supra.*) The regulatory scheme could not "work." Blue Cross was represented on the HSA which developed the Health Systems Plan, as provided in the Act. It cooperated in implementing the HSP, as provided in the Act. It confounds logic to imagine that Congress, having summoned providers to cooperate in implementation, intended to leave them exposed to antitrust liability for following the Health Systems Plan to the letter. The statutory scheme would have been a legislative absurdity if the very activity it was designed to encourage could become the basis for an antitrust claim.

Petitioner and the Solicitor General cite various cases for the proposition that even where there is formal agency approval, there can be no implied repeal in the absence of an express exemption from the antitrust laws. (Pet. Br. at 29; S.G. Br. at 21). But in each of these cases the Court found that the regulatory scheme was reconcilable with antitrust because Congress, in fact, intended the antitrust laws to apply. *United States* v. *Radio Corporation of America,* 358 U.S. 334, 339-46 (1959); *California* v. *Federal Power Commission,* 369 U.S.

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28 In contrast, it would be illegal in the usual commercial context for a group of companies to get together to limit production. *See, e.g.,* Westinghouse Elec. Corp. v. Gulf Oil Corp., 588 F.2d 221, 226 (7th Cir. 1978).

482, 486 (1962); *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 352 (1963). (Pet. Br. at 23-24; S.G. Br. at 21).

Moreover, all of these cases involved traditional, adversarial regulatory schemes bearing little resemblance to health planning. The Communications Act, 47 U.S.C. § 309, the Interstate Commerce Act, 49 U.S.C. § 10706, the Federal Aviation Act, 49 U.S.C. § 1384, and similar federal regulatory provisions, are all grounded in the theory that a limited competitive market—presided over by the watchful eye of the federal regulatory apparatus—will best promote the public interest.

The Health Planning Act has a policy basis quite distinct from these traditional regulatory provisions. As we have shown, the Act is an exercise in cooperation, a joint effort among government and private entities. (*See* pp. 24-28 *supra*).

Petitioner's further statements that Blue Cross really was engaged in unsupervised activity, acting as a "private government" or "extra-judicial tribunal," with "no public oversight of any kind," are incorrect and misleading. (Pet. Br. at 27, 31; *see also* S.G. Br. at 22). Not only did the Health Planning Act of 1974 call for "implementation" by providers such as Blue Cross (*see* p. 25 *supra*), but the fact of the matter is that Blue Cross established no community need standards of its own. Blue Cross simply followed the precise determinations of MAHSA, requiring only that "institutional services shall be approved . . . by the . . . area-wide health planning agency." (J.A. at 146a). This situation is worlds apart from *Fashion Originators Guild* v. *FTC*, 312 U.S. 457, 465 (1941), where an industry group sat as legislature, judge and jury.[29]

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29 In the cases cited by petitioner and the Solicitor General (Pet. Br. at 27; S.G. Br. at 22-23), the private entities involved were making judgments beyond the contemplation of any regulatory scheme and not in furtherance of the goals of any regulatory scheme. *See* Silver v. New York Stock Exchange, 373 U.S. 341, 361 (1963) (challenged conduct did not serve any purpose reflected in the SEC Act); Otter Tail Power Co. v. United States, 410 U.S. 366, 373-74 (1973) (conduct did not further the goals of the Federal Power Act); United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 227 (1940) (conduct was not within the contemplation of the National Industrial Recovery Act); Fashion

Faithful to its federal mandate, MAHSA, which was no officious intermeddler, made a reasoned determination, following an investigation and public hearings, that additional hospital beds in the Kansas City area were unwarranted. (J.A. at 102a). Blue Cross did nothing more than carry out MAHSA's determination, as provided under the cooperative system established by the Act. *See* p. 25 *supra*. Not only were MAHSA's investigation and Health Systems Plan required by the Health Planning Act of 1974, but every step of MAHSA's procedure was carried out pursuant to the detailed requirements of the Act.[30] As stated by the Solicitor General, "HSA decisionmaking is public and open, and carefully supervised." (S.G. Br. at 16 n.11). The "real decision-maker" (Pet. Br. at 30) here was MAHSA, not Blue Cross.

Moreover, MAHSA's determination was subject to review. Although petitioner complains that there was no mechanism for review (Pet. Br. at 33), it could have sought reconsideration of MAHSA's determination of hospital bed oversupply at the time the HSP was formulated. *See* 42 U.S.C. § 300*l*-2(b)(2). It could have sought reconsideration after the Plan was issued. In fact, petitioner never approached MAHSA at all. If petitioner were dissatisfied with MAHSA's response, it could have sought review by the Secretary of HEW of the Plan's adequacy in conjunction with HEW's review of MAHSA's performance, 42 U.S.C. § 300n-4(c)(1), or the renewal of MAHSA's grant. 42 U.S.C. § 300n-4(a). Petitioner did none of those.

Petitioner's additional assertion that, under this Court's decisions, "pervasive regulatory powers" must exist as a precondition to finding implied repeal, is incorrect. (Pet. Br. at 25, 38-41). In *Gordon* v. *New York Stock Exchange, Inc.*, 422

Originators Guild v. FTC, 312 U.S. 457, 465 (1941) (conduct not within the contemplation of, or in furtherance of the goals of any federal regulatory scheme); Associated Press v. United States, 326 U.S. 1, 12-13 (1945) (same); American Medical Ass'n v. United States, 317 U.S. 519, 535-36 (1943) (same).

30 *See* note 10 *supra*. Petitioner does not claim that MAHSA failed to perform any of these obligations.

U.S. 659, 688-89 (1975), this Court stated that a pervasive regulatory scheme is *not* an essential ingredient of the implied repeal doctrine:

> "The United States appears to suggest that only if there is a pervasive regulatory scheme, as in the public utility area, can it be concluded that the regulatory scheme ousts the antitrust laws. . . . It is true that in some prior cases we have been concerned with the question of the pervasiveness of the regulatory scheme as a factor in determining whether there is an implied repeal of the antitrust laws. . . . In the present case, however, respondents do not claim that repeal should be implied because of a pervasive regulatory scheme, but because of the specific provision of § 19(b)(9) and the regulatory action thereunder. . . . Hence, whether the Exchange Act amounts to pervasive legislation ousting the antitrust acts is not a question before us." (Citations omitted).

In any event, this Court need not reach the issue on the facts of this case. There is a pervasive regulatory scheme, since, as pointed out, *supra,* p. 27, the decision-maker here was MAHSA, and Congress intended that MAHSA's Health Systems Plan would embrace all activities with respect to new health services, such as those in issue.

Contrary to the suggestions of petitioner, respondents are not seeking a "blanket exemption." It is revealing that petitioner addresses most of its attention to the district court opinion below, which it claims conferred a "blanket exemption," and devotes far less attention to the Court of Appeals, which drafted its own analysis and never mentioned a blanket exemption. (*Compare* Pet. Br. at 6-7, *with* Pet. Br. at 8).[31] Petitioner claims that the decision below "would provide an umbrella of protection for many types of anticompetitive

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31 The *amicus* Federation of American Hospitals acknowledges that "[t]he Eighth Circuit did not . . . find that the Act created a 'blanket exemption' . . ." (F.A.H. Br. at 5).

activities, so long as they could be said to be in some way consistent with the goals of the Planning Act." (Pet. Br. at 13). So, too, the Solicitor General implies that respondents claimed and were granted antitrust immunity here "simply because Blue Cross may have believed that its alleged exclusionary practices were in furtherance of a general regulatory purpose such as avoiding unnecessary expenditures or duplication of services." (S.G. Br. at 21). This is erroneous—the Court of Appeals adhered to this Court's decisions in *NASD* and *Gordon,* citing and quoting them. (*See* J.A. at 206a, 209a).

The "issue" of blanket exemption is, however, a red herring. Respondents are not seeking an "umbrella of protection" for every type of conduct which is somehow "consistent" with the Act. On the facts of this case, implied repeal is essential to make the statutory scheme work and to avoid frustrating the purpose of Congress. If private entities cooperating with HSAs to implement the precise words of the Health Systems Plan might be liable under the antitrust laws for such action, there would be no implementation at all.

Congress has chosen to enact forms of regulation aimed at "preventing unnecessary duplication," which are based on cooperation with private entities; that choice should not be frustrated by visiting insurers and other providers with exposure to treble damage antitrust suits. The Solicitor General's comment that there is "no basis for inferring that subjection of Blue Cross' conduct to antitrust scrutiny would frustrate any of the [Act's] goals," is erroneous. (S.G. Br. at 13). It makes no difference that, as the Solicitor General recognizes (S.G. Br. at 11 n.8), petitioner would confront several substantive antitrust law barriers to recovery against Blue Cross, if this case were to be tried on the merits. The threat of litigation provides enough of a chilling effect. Congress did not intend that providers such as non-profit Blue Cross should become embroiled in costly antitrust litigation—the expense of which is ultimately borne by its subscribers—to defend claims of "conspiracy" to restrain trade, where all Blue Cross has done is follow the very Health Systems Plan promulgated by the federally established and funded MAHSA.

IV. The Inclusion of an Exemption for Individual Liability in the Health Planning Act of 1974 Has Nothing To Do With Finding an Implied Repeal of Antitrust Here

In the 1974 proceedings there was not a whisper of a wish in Congress to have competition. As described above, the entire thrust of the Health Planning Act of 1974 was to substitute planning for market forces. "[I]n fact," as stated by the *amicus* Federation of American Hospitals, "the subject of antitrust was not an issue while the [1974] Act was being considered." (F.A.H. Br. at 18).

This is not surprising since at the time the 1974 Act was passed, there were very few cases applying antitrust to the types of conduct contemplated in the Act. Indeed, petitioner itself has pointed to "the substantial immunity from the antitrust laws that the health care sector and third-party reimbursement organizations such as respondent Blue Cross have enjoyed in the past." (Petition for a Writ of Certiorari at 8).[32] In 1974 there was no reason for antitrust liability to be an issue during consideration of the Health Planning Act.

Despite this, petitioner and the *amici* make the argument that implication of an antitrust repeal is barred here by the principle of *"expressio unius"* because the 1974 Act, and the

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32 So, too, petitioner stated, "[u]ntil very recently, health care providers and insurers were largely immune from the federal antitrust laws because of various legal hurdles which effectively shielded their conduct from antitrust scrutiny." (Petition for a Writ of Certiorari at 12).

Then, in 1975, this Court's decision in Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975), reversed the Court of Appeals and applied antitrust to the "learned professions." In 1976, in Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738 (1976), this Court, again reversing the Court of Appeals, applied antitrust to hospitals affecting interstate commerce. And, in 1979, the 5-4 decision in Group Life & Health Insurance Co. v. Royal Drug Co., Inc., 440 U.S. 205 (1979), limited the McCarran-Ferguson antitrust exemption for insurers such as Blue Cross, in contrast to several lower court decisions which preceded it. *See, e.g.*, Nankin Hospital v. Michigan Hospital Service, 361 F. Supp. 1199, 1210-11 (E.D. Mich. 1973); Travelers Insurance Co. v. Blue Cross of Western Pennsylvania, 481 F.2d 80, 82-83 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973).

1979 Act, contain express exemptions from certain types of liability.

Again, only the 1974 Act is relevant. The 1974 Act contained a boilerplate exemption from liability for members and employees of an HSA:

> "Individual Liability.—No individual who, as a member or employee of a health systems agency, shall, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by, the agency under this title, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if he has acted within the scope of such duty, function, or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it." Pub. L. No. 93-641, § 1512(b)(4), 88 Stat. 2225, 2235.[33]

This is merely an exemption from liability to avoid discouraging individuals from serving on HSAs. Although petitioner labels it "a limited immunity from antitrust (and other) damage actions" (Pet. Br. at 18), no one in Congress in 1974 related it to antitrust liability and the limited express exemption for individuals teaches nothing about the intent of Congress with regard to this case.[34] The cases cited by petitioner,

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33 The 1974 exemption is typical of the numerous federal statutes which, in language akin to the 1974 exemption, exempt government employees from personal liability for acts done within the scope of their employment and in good faith. *See, e.g.*, 2 U.S.C. § 170(c) (librarian and employees of Library of Congress); 15 U.S.C. § 78kkk(c) (directors, officers, and employees of Securities Investor Protection Corporation); 19 U.S.C. § 1513 (customs officers); 40 U.S.C. § 489(a) (governmental employees charged with transfer and disposal of government property); 42 U.S.C. § 300j-6(a) (officers, agents, and employees of the United States charged with public water systems safety).

34 As noted by *amicus*, Federation of American Hospitals, the Senate Committee "did not in any fashion indicate that the Senate *considered* or attempted to exempt members of the health care industry from . . . the antitrust laws." (F.A.H. Br. at 18) (emphasis added). The Solicitor

on the other hand, deal with statutes having express exemptions explicitly addressed to "competition" or "antitrust." (Pet. Br. at 19).[35]

To be sure, in 1979, after *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773 (1975); *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738 (1976); and *Group Life & Health Insurance Co.* v. *Royal Drug Co., Inc.,* 440 U.S. 205 (1979) had been decided, and at a time when Congress was adding provisions aimed at encouraging competition for prepaid and outpatient services (*see* p. 17 *supra*), Congress added onto the exemption a specific exemption from liability for HSAs themselves when performing functions required or authorized by the 1979 Act. It also modified the provision for individual members and employees. Whether these changes in 1979 were intended to alter the existing implied repeal of antitrust, which Congress had intended in 1974, is not a question which this Court must reach. The only issue here is the scope of the implied repeal of the 1974 Health Planning Act itself. For the same reason, the hearing testimony cited by petitioner regarding the proper scope of immunity—all of which was given *in 1979*—is irrelevant for purposes of applying the 1974 Act to the facts of this case. (*See* Pet. Br. at 19-20). It is worth noting, however, that if the HSA is immune from liability—as provided explicitly under the 1979 Act—for "conspiring" with Blue Cross, it would make no sense to subject Blue Cross to liability for engaging in the same alleged conspiracy. *See Alabama Power Co.* v. *Alabama Electric Cooperative, Inc.,* 394 F.2d 672, 676-77 (5th Cir.), *cert. denied,* 393 U.S. 1000 (1968) ("To avoid frustrating the intent of Congress, it must follow that in cases where the Administrator is immune from

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General's reference to "Congress' *considered decision* to grant only a limited express immunity," is groundless. (S.G. Br. at 9) (emphasis added).

35 Federal Maritime Commission v. Seatrain Lines, Inc., 411 U.S. 726, 732-33 (1973); Carnation Co. v. Pacific Westbound Conference, 383 U.S. 213, 216 (1966); United States v. Borden Co., 308 U.S. 188, 201 (1939); Cain v. Air Cargo, Inc., 599 F.2d 316, 320 (9th Cir. 1979).

suit under the antitrust laws, the borrower is likewise immune"); *Champaign-Urbana News Agency Inc.* v. *J.L. Cummins News Co.*, 632 F.2d 680, 692-93 (7th Cir. 1980).

Moreover, the basic premise of petitioner's argument is erroneous as a matter of law. The inclusion of an express immunity provision in a statute does not preclude a finding of implied immunity. In *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, 720-22 (1975), immunity was implied because of § 22(f), despite the inapplicability of the express provision in § 22(d) of the Investment Company Act of 1940. And in *Pan American World Airways, Inc.* v. *United States*, 371 U.S. 296, 305-10 (1963), implied immunity was applied to transactions that could not be immunized under the express antitrust exemption of § 414 of the Federal Aviation Act. Here, where the specific exemption in the 1974 Act was unrelated to antitrust, the principle of *expressio unius* has even less—considerably less—applicability.

CONCLUSION

The Court of Appeals correctly determined that the intent of Congress in the Health Planning Act of 1974—to prevent unnecessary duplication of hospital facilities, to specify health planning and to implement this planning through cooperation with private entities such as Blue Cross—included repeal of the antitrust laws in the specific circumstances of this case. The repugnancy between the Health Planning Act of 1974 and the antitrust laws is underscored by the facts here, where Blue Cross did nothing more than implement the MAHSA Health Systems Plan in its precise terms.

For the reasons described above, we respectfully request that the order of the Court of Appeals be affirmed.

Respectfully submitted,

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APPENDIX

STATUTORY PROVISIONS INCLUDED

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. . . ."

Section 2 of the Sherman Act, 15 U.S.C. § 2, provides in pertinent part:

> "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony. . . ."

The relevant provisions of the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.* provide in pertinent part:

Section 300k(a):

> "The Congress makes the following findings:
>
> (1) The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.
>
> (2) The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.

(3) The many and increasing responses to these problems by the public sector (Federal, State, and local) and the private sector have not resulted in a comprehensive, rational approach to the present—

(A) lack of uniformly effective methods of delivering health care;

(B) maldistribution of health care facilities and manpower; and

(C) increasing cost of health care.

(4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.

(5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels.

(6) Large segments of the public are lacking in basic knowledge regarding proper personal health care and methods for effective use of available health services."

Section 300k(b):

"In recognition of the magnitude of the problems described in subsection (a) of this section and the urgency placed on their solution, it is the purpose of this Act to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy."

Section 300*l*-2(c):

"A health systems agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:

(1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area."

Section 300*l*-2(f):

"To assist State health planning and development agencies in carrying out their functions under paragraphs (4) and (5) of section 300m-2(a) of this title each health systems agency shall review and make recommendations to the appropriate State health planning and development agency respecting the need for new institutional health services proposed to be offered or developed in the health service area of such health systems agency."